PRINTED: 03/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		A. Bollbing			С		
185262		B. WING			12/11/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	E		
MADISON	HEALTH AND REHABIL	ITATION CENTER		131 MEADOWLARK DRIVE RICHMOND, KY 40475			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
F 456	on 12/09/15 and cond complaint was unsub- deficient practice was	ntain all essential I, and patient care	F 4	.56			1/25/16
	by: Based on observation policy review it was defailed to maintain wat safe operating condition temperatures observed specified range (100% according to Kentuck Regulations. Observed on 12/09/15 revealed resident rooms and of rooms had water temps specified range.  The findings include:  Review of the facility Temperatures," undar	to 110 degrees Fahrenheit )					
	100 degrees Fahrenh Observation of the wa	neit (F) and 110 degrees F.  ater temperature in resident at 10:45 AM revealed the					
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(	X6) DATE

01/06/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			A. BOILD	NG		Ι,	C
		185262	B. WING		<del> </del>	1	
NAME OF P	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MADISON	HEALTH AND REHA	BII ITATION CENTED		131	I MEADOWLARK DRIVE		
WADISON	HEALTH AND KEHA	BILITATION CENTER		RIC	CHMOND, KY 40475		
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F 456	Continued observation resident room 1 revealed the water F. Observation of at 2:40 PM revealed sink to be 94 degrated to be 95 degrated to be 96 degrated to be 96 degrated to be 96 degrated to be 95 degrated to	age 1 at the sink to be 98 degrees F. ation of the water temperature 6 on 12/09/15 at 2:46 PM remperature to be 94 degrees resident room 14 on 12/09/15 at the water temperature at the ees F. Observation of resident 15 at 2:44 PM revealed the at the sink to be 94 degrees F. ident room 16 on 12/09/15 at the water temperature at the ees F. Observation of resident 15 at 2:47 PM revealed the at the sink to be 97 degrees F. ident room 21 on 12/09/15 at the water temperature at the ees F. Observation of the om (on the hall with resident 2/09/15 at 2:55 PM revealed ture at the showerhead to be the water temperature at the ees F. Observation of resident 15 at 2:59 PM revealed the at the sink to be 95 degrees. ident room 22 on 12/09/15 at the water temperature at the ees F. Observation of resident 15 at 3:02 PM revealed the at the sink to be 95 degrees F. ident room 24 revealed the at the sink to be 96 degrees F. ident room 25 on 12/09/15 at the water temperature at the ees F. Observation of resident 15 at 3:36 PM revealed the at the sink to be 96 degrees F. ident room 25 on 12/09/15 at the water temperature at the ees F. Observation of resident 15 at 3:36 PM revealed the at the sink to be 94 degrees F. ident B on 12/09/15 at 10:30	F	456			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185262	B. WING _			C <b>12/1</b>	1/2015	
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER			•	STREET ADDRESS, CITY, STATE, ZIP C 131 MEADOWLARK DRIVE RICHMOND, KY 40475	:ODE			
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F 456	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 problems with the water in his/her room not being warm enough when the nurse aides were providing care. Continued interview with Resident B revealed he/she had reported the water temperature issues to the Facility Administrator approximately two weeks ago.  Interview with State Registered Nurse Aide (SRNA) #1 on 12/10/15 at 10:44 AM revealed she had been aware of the facility having issues with the water temperatures and had reported the water temperature issues multiple times in the past; however, SRNA #1 was not able to remember exactly who she had reported to. Continued interview with SRNA #1 revealed Resident B had complained to her in the past about his/her water temperature not being warm enough when the nurse aides were providing care. Continued interview with SRNA #1 revealed the facility had been having issues with the water temperatures for approximately the last year.  Interview with SRNA #2 on 12/10/15 at 11:31 AM revealed she had observed the water temperatures to get cooler throughout the day.  Interview with Licensed Practical Nurse (LPN) #1 on 12/10/15 at 1:16 PM revealed she had observed one of the SRNAs bringing warm water out of the employee break room to use for residents. Continued interview with LPN #1 revealed she was aware of a resident getting a cold shower approximately two weeks ago. Further interview with LPN #1 revealed the facility had been having issues with the water temperatures for approximately two weeks ago.		F 4	156				

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		185262	B. WING _			C <b>12/11/2015</b>		
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		12/11/2013		
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F 456	456 Continued From page 3		F 4	56				
	with the UM revealed Resident B having a temperature in his/ho Interview with the Ed (ETD) on 12/10/15 a facility had constant	facility. Continued interview d she had not been aware of any issues with the water er room.  Jucation Training Director t 2:27 PM revealed the						
	approximately one y	5 5						
	12/10/15 at 3:32 PM residents had made the water temperatur cold. Continued interests	any complaints to her about res in the facility being too rview with the DON revealed made any complaints about						
	12/09/15 at 2:25 PM been aware of needi order improve the ho interview with the MI the Facility Administr month ago and to da else about it. Further 12/09/15 at 2:57 PM identified any issues in the facility in the printerview with the MI temperatures every	•						
	3:13 PM revealed sh facility needing a rec been aware the water	Iministrator on 12/09/15 at the had been aware of the irculating pump, but had not er temperatures in the facility of the specified range.						

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		125000				С	
NAME OF D	DOVIDED OD CURRUED	185262	B. WING		TREET ARRESTOR OFFICE AIR CORE	12/	11/2015
NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH AND REHABILITATION CENTER				13	TREET ADDRESS, CITY, STATE, ZIP CODE  31 MEADOWLARK DRIVE  ICHMOND, KY 40475		
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